Section C
Medicare introduction

Background

Medicare is a federal health insurance program for:

- People 65 and older
- Some people with disabilities under 65
- Those with end stage renal disease
- Those with Lou Gehrig's Disease (immediately upon diagnosis because of the short life expectancy)

- Medicare was created as part of Lyndon B. Johnson's Great Society Program. Medicare was the first large federal health insurance program established by the United States government.

- Medicare was enacted into law in 1965 as part of the Social Security Act and became effective July 1, 1966.

- Medicare covers beneficiaries in 50 states, Washington, D.C. and U.S. territories and possessions: U.S. Virgin Islands, Northern Mariana Islands, American Samoa, Puerto Rico and Guam.

- Medicare has four parts: hospital insurance (Part A), medical insurance (Part B), Medicare Advantage plans (Part C) and prescription drug coverage (Part D):
  a. **Hospital insurance (Part A)** helps pay for:
     - Inpatient hospital care
     - Limited skilled nursing facility care
     - Home health care following a hospital stay
     - Hospice care
  b. **Medical insurance (Part B)** helps pay for:
     - Physician services
     - Outpatient services
     - Durable medical equipment
     - Home health care when there has been no hospital stay
  c. **Medicare Advantage (MA) (Part C)** offers Medicare beneficiaries the opportunity to enroll in private health care plans that require them to share part of the cost of health care services.
  d. **Prescription drug coverage (Part D)** provides people with Medicare the option of enrolling in private Prescription Drug Plans (PDPs) or Medicare Advantage plans with prescription drug coverage (MA-PD).

- Medicare was never intended to pay 100 percent of medical bills. Like private health insurance, there are "gaps" in Medicare where the beneficiary must pay a portion of medical expenses. Beneficiaries share the cost by paying:
  a. **Deductible**: A flat dollar amount the beneficiary is responsible for before Medicare coverage will begin.
  b. **Coinsurance or copayment**: A percentage or dollar amount of covered expenses which the beneficiary is required to pay.

- Medicare only pays for services determined to be reasonable and necessary for the diagnosis or treatment of a specific illness or injury. Decisions about what is reasonable and necessary are always based on professional medical advice.

Medicare administration

Medicare benefits are administered by the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. Medicare is ultimately controlled by the U.S. Congress.

- CMS contracts with insurance companies to handle Medicare claims. A company which handles Part A claims is called a **fiscal intermediary**. A company which handles Part B claims is called a **carrier**.

- In North Dakota, Blue Cross Blue Shield of North Dakota (Noridian) handles most Part A and Part B claims.

  Noridian Medicare
  901 40th Street South, Suite 1
  Fargo, ND 58103-2146
  1-800-633-4227
  www.noridianmedicare.com

  a. Other claims include:
  Durable medical equipment (DME) claims are handled on a regional basis. Our region is served by:

  Noridian Medicare
  901 40th Street South, Suite 1
  Fargo, ND 58103-2146
  1-800-633-4227
  www.noridianmedicare.com

  Home health care claims and hospice are processed by:

  Government Benefit Administrators
  Medicare Part A
  1201 Zenith Drive, Suite 100
  Sioux City, IA 51103-5217
  (712) 293-5800

  Railroad Retiree Medicare Part A claims are processed by:

  Noridian Medicare
  901 40th Street South, Suite 1
  Fargo, ND 58103-2146
  1-800-633-4227
  www.noridianmedicare.com

  Railroad Retiree Medicare Part B claims are processed by:

  Palmetto Government Benefits
  Administrators GBA
  P.O. Box 10066
  Augusta, GA 30999-0001
  1-800-833-4455

Eligibility

Medicare **eligibility and enrollment** are handled by a separate federal agency, the Social Security Administration.

American citizens are eligible for Medicare if:

- They are 65 years or older
- Eligible under their own work record
- Eligible under that of their spouse for Social Security, railroad or civil service retirement plans

*If the beneficiaries birthday is on the first of the month, they will be eligible for Medicare the prior month.

2. They have end stage renal disease and are receiving dialysis on a regular basis or have received a kidney transplant due to kidney failure.

3. They are any age and eligible for disability benefits under Social Security, railroad or civil service retirement plans.

A. Under Social Security and Railroad Retirement plans, the individual must have been receiving Social Security disability benefits for at least 24 months.
B. Those diagnosed with Lou Gehrig's disease (ALS or Amyotrophic Lateral Sclerosis) will receive Medicare benefits the first month Social Security disability benefits are received.
C. Under civil service retirement the individual must have been disabled for 29 or more months.

4. A person 65 or older who is not eligible for Social Security benefits may purchase Medicare coverage if that person is:

A. An American citizen; or
B. An alien lawfully admitted for permanent residence who has resided in this country five consecutive years before applying for Medicare.

Costs will be discussed in a later chapter.

Enrollment

Enrollment in Part B can happen automatically or during three different types of enrollment periods: initial, general and special.

1. **Automatic enrollment**: Individuals receiving Social Security benefits prior to age 65 should be automatically enrolled. Coverage begins the first day of their birth month if they are 65 years old or the first day of the 25th month of recurring benefits.

A. These individuals receive a Medicare card in the mail from Social Security three months before their 65th birthday notifying them of their enrollment in Medicare Part A and Part B. If they do not want Part B, they must return the form appropriately marked and they will be enrolled for Part A only.
B. If no card is received, a person should contact the nearest Social Security Administration office prior to their 65th birthday.

2. **Initial enrollment**: The initial enrollment period applies to individuals just turning 65 who have not been receiving Social Security benefits.

A. The seven-month initial enrollment period begins three months prior to the individual's birth month and ends three months following the individual's birth month.

Initial enrollment

Month 1	Month 2	Month 3	Birth month	Month 5	Month 6	Month 7

B. The month of enrollment determines when Medicare coverage becomes effective:

- Individuals who enroll during the three months prior to their birth month are covered beginning on the first day of their birth month.
- An individual enrolling during his/her birth month will be covered beginning on the first day of the following month.
- If the individual enrolls during the month following his/her birth month, coverage begins two months later.
- If the individual enrolls during the second or third months after his/her birth month, coverage begins three months later.

3. **General enrollment**: The general enrollment period is an annual enrollment opportunity for anyone who did not sign up for Part B during the initial enrollment period. General enrollment runs from January 1 through March 31 each year.

General enrollment

January	February	March	Coverage begins July 1

A. For people who enroll during general enrollment, coverage begins on July 1 of that year.

B. People who wait until the general enrollment period to sign up for Part B are charged a 10 percent premium surcharge for each 12-month period they delay in enrolling (e.g., if they delay 5 years, the surcharge is 50 percent).

4. **Special enrollment (SEP)**: The special enrollment period applies to those who:

A. Continue to work past age 65 and are covered under an employer group health plan

- Retired individuals who are covered under a working spouse's employer group health plan (EGHP)
- These individuals must notify Social Security of their intent to remain covered by the EGHP.
- These individuals may enroll at anytime after age 65 but they **must** enroll no later than eight months after the month of their retirement or of the person who is working.
- They also have the option of enrolling anytime during the year while they are still working if they decide they want Medicare coverage or if their EGHP is discontinued.
- If any individual enrolls in any other month, coverage begins the month following.
- Individuals who are eligible for special enrollment are not penalized with a 10 percent surcharge provided they enroll no later than eight months after the month of retirement.

B. Other circumstances may qualify for an SEP. Ask the SHIC program counselors for more information. The length of the SEP may vary by SEP.

Special enrollment

Retire month	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Month 7	Month 8

Medicare card

Social Security issues each beneficiary a Medicare card.

1. The card shows
    - A. Which part(s) of Medicare the beneficiary has
    - B. His/her name
    - C. Medicare or health insurance number
    - D. Effective date of coverage

2. The number on the card is the Social Security number of the beneficiary, his/her spouse or parent, depending under which work record the individual has become eligible.

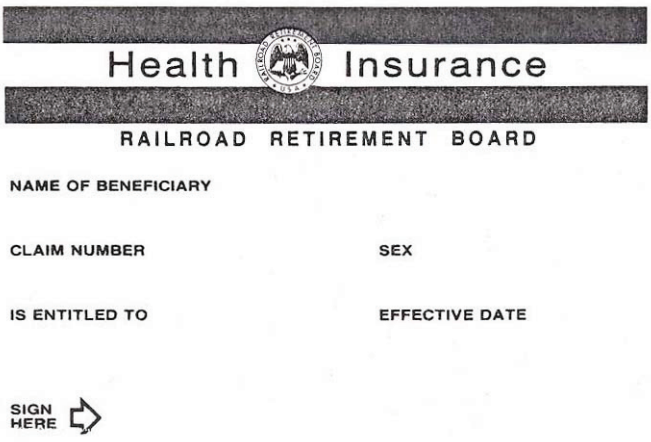
3. The number will be followed by a letter designation if eligibility occurs through Social Security retirement. The number will be preceded by a letter designation if eligibility occurs through railroad or civil service retirement.

4. If a person loses his/her card or has questions regarding Medicare enrollment, they should contact their local Social Security office or use the website to request a replacement card online:

- North Dakota toll-free Social Security 1-800-453-7255
- National toll-free Social Security 1-800-772-1213
- www.socialsecurity.gov

Sample Medicare cards

Pictured here is the redesigned card that Medicare has been issuing since 1990. The old card, which does not say "Medicare" in the banner at the top, is still valid.



Railroad Retirement Insurance Card

Payment system

Medicare has established standardized payment systems for services it will cover.

1. Since Sept. 1, 1990, both Part A and Part B providers are required by law to file all Medicare claims for their patients.

2. Medicare pays for most inpatient hospital (Part A) care, home health care and skilled nursing facility care under the Prospective Payment System (PPS). The facilities are paid a set rate based on payment categories called "diagnosis related groups" (DRGs).

A. The amount the facility is paid depends on the individual's diagnosis.
B. In some cases the Medicare payment may be more than the facility's costs; more often the payments will be less than the facility's costs.
C. **Hospitals, home health agencies, ambulance companies and skilled nursing facilities must "accept assignment."** They must accept the Medicare fee schedule as payment in full–they may not pass on the difference to the beneficiary.
D. The beneficiary will owe only the deductible and/or coinsurance on Medicare-covered services.
E. In case of extra long stays or very high costs associated with particularly complex cases (known as "outliers"), Medicare can make an extra payment to the hospital.

3. Payments for Medicare Part B services are based on a **national fee schedule** and whether or not the Part B provider is a Medicare participating provider (accepts assignment).

A. The fee schedule assigns a dollar value to each service based on work practice costs and malpractice insurance costs. It is the basis for the Medicare approved amount for Medicare-covered services and may vary from region to region around the country.

4. Three ways for facilities to receive payment
A. **Participating providers** accept the Medicare approved amount from the fee schedule as payment in full. The beneficiary owes only the deductible and coinsurance on Medicare-covered services (also referred to as "accepting assignment").
B. **Nonparticipating providers** may charge beyond the fee scale within limits. The beneficiary may owe up to 15 percent more than the Medicare approved amount, in addition to the deductible and coinsurance.
C. The Balanced Budget Act of 1997 allows for private contracts between physicians and Medicare beneficiaries for Medicare covered services.

Part A payment: based on patient diagnosis

Part B payment: based on services received

Advance beneficiary notice (ABN)

Under limited circumstances, a beneficiary cannot be required to pay for services even if Medicare denies the claim. Prior to performing a service, the provider has to have the beneficiary' sign a statement saying Medicare will likely not cover the services. This statement is called an advance beneficiarly notice (ABN).

1. Waiver of liability occurs when Medicare has **denied coverage** of a Medicare covered service and the beneficiary **did not know and did not have reason to know** that Medicare would deny coverage.

2. In order for the beneficiary to know that services would be denied, the provider must inform the beneficiary **prior to performing the service** that denial is expected and why.

3. If the beneficiary did not sign an advance beneficiary notice (ABN) **specific to the service or procedure** and Medicare denies the claim, he/she may not be required to pay the provider. In some cases the beneficiary may be liable for applicable deductibles and coinsurance.

4. **An ABN does not apply to services not covered by Medicare** or to ambulance claims in most cases. In these the provider does not have to notify the beneficiary of expected denial.

5. If neither the beneficiary nor the provider could have been expected to know that expenses incurred were excluded from coverage, Medicare will cover the cost.

Secondary payer

When more than one payer may be liable for a claim, benefits must be coordinated to prevent duplicate payment of claims. In the following circumstances, Medicare pays after the other payer's liability has been exhausted.

1. Items or services covered by a governmental agency or program (e.g., workers compensation and VA).

2. Items or services covered under an employer's group plan when the plan is the primary payer (e.g., the working aged, working people with permanent kidney failure and certain disabled people).

> Three months prior to turning 65 an Initial Enrollment Questionnaire (IEQ) is sent to all Medicare eligible beneficiaries. The questionnaire is a means for establishing when Medicare is the primary or secondary payer or if the beneficiary has other health coverage. Questions may be asked when treatment is needed to determine what is primary. This process of determining who pays first or second is called coordination of benefits.

3. Items or services covered under liability or no-fault insurance (e.g., homeowners and auto).

Dear _____,

You are or will soon be entitled to Medicare. To help us complete your Medicare file, it is important for you to fill out the enclosed questionnaire and return it within two (2) weeks. Without this information, we may not be able to process your claims properly. The questionnaire will only take you about five (5) minutes to finish.

The purpose of this questionnaire is to find out if you have other coverage that should pay your medical claims first. It is important for all Medicare beneficiaries to accurately complete this short questionnaire, even if you do not have any other health care insurance. This assures your file is complete and your claims can be paid promptly.

Please return your completed questionnaire within two (2) weeks. Mail your completed questionnaire in the enclosed pre-printed envelope to:

MEDICARE Coordination of Benefits
Initial Enrollment Questionnaire Project
P.O. Box 17521
Baltimore, MD 21203-7521

Telephone number: 1-800-999-1118
TTY/TDD: 1-800-318-8782 (for the hearing and speech impaired)

If you have any questions or need help completing the questinnaire, please call the toll-free number listed above. If you want to learn more about Medicare, please visit our web page at www.cms.hhs.gov/COBgeneralinformation. If you would like the questionnaire in Spanish, please write to us at the above address, or call the toll-free number. *Si desea el cuestionario en Espanol, por favor excribanos a la direccion mencionada o llamenos a nuestro numero telefonico gratis.*

THIS INFORMATION IS BEING COLLECTED UNDER CONTRACT WITH THE UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, CENTERS FOR MEDICARE & MEDICAID SERVICES FOR USE BY THE MEDICARE PROGRAM.

FOR YOUR INFORMATION ONLY

NOTICE TO PATIENTS ABOUT THE COLLECTION AND USE OF MEDICARE INFORMATION PRIVACY ACT STATEMENT

The Social Security Act mandates the collection of information to be used to set up your Medicare file. The purpose of collecting this information is to properly pay medical insurance benefits to you or on your behalf.

Information may be given to health insurance providers and suppliers of services (and their authorized billing agents) directly or through fiscal intermediaries or carriers, for administration of Title XVIII; and to an individual or organization for research evaluation, or epidemiological projects related to the prevention of disease or disability, or the restoration or maintenance of health.

The identification number we are using to set up your file is your Medicare Health Insurance Number. While furnishing the information on the enclosed form is voluntary, the Medicare program may not be able to make accurate claims payment when the requested information is not available in its records.

Public Law 100-503, the Computer Matching and Privacy Protection Act of 1988, permits the government to verify information by way of computer matches. Anyone who knowingly and willfully makes or causes to be made a false statement or representation of a material fact for use in determining a right to payment under the Social Security Act commits a crime punishable under federal law by fine, imprisonment or both.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0214. The time required to complete this information collection is estimated to average five minutes per response, including the time to review instructions, search existing data resources, gather the data needed and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, ATTN: PRA Reports Clearance Officer, 7500 Security Boulevard, Baltimore, MD 21244-1850.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

QUESTIONS CALL: 1-800-999-1118

MEDICARE QUESTIONNAIRE FOR BENEFICIARIES 65 OR OVER

NAME	DATE OF BIRTH	MEDICARE NUMBER

INSTRUCTIONS: This form will be read by a computer. Please print as shown below. Stay within the boxes. Use CAPITAL letters. Mark boxes with an X. **USE BLACK OR BLUE INK.**

EXAMPLE | | A | B | C | | | 1 | 2 | 3 | | |

SECTION A - INFORMATION ABOUT YOU

1) On 04/01/2006, will **YOU** be working? **YES** ☐ **NO** ☒ (If **NO**, go to **SECTION B**)

2) Do **YOU** have any group health plan coverage through your current employer?
YES ☐ **NO** ☒ (If **NO**, go to **SECTION B**)

3) How many employees, including yourself, work for your employer?
☐ **Don't know** ☐ **20 or more** ☐ **Less than 20** (If less than 20, **STOP**, go to **SECTION B**)

Please provide information about the employer and the employer group health plan in the spaces below:

EMPLOYER NAME

ADDRESS

ADDRESS

CITY STATE ZIP

NAME OF GROUP HEALTH PLAN

ADDRESS

ADDRESS

CITY STATE ZIP

GROUP IDENTIFICATION NUMBER

POLICY NUMBER

4) Does your employer group health plan cover prescription drugs? **YES** ☐ **NO** ☐ (If **NO**, go to **SECTION B**)
Please use your insurance card to provide the following information if available:

Rx GROUP Rx PCN

MEMBER ID Rx BIN

SECTION B - INFORMATION ABOUT YOUR HUSBAND/WIFE

1) On 04/01/2006, will you be receiving any group health plan coverage through the current employment of your husband/wife? **YES** ☐ **NO** ☒ **N/A** ☐ (If **NO** or **N/A**, **STOP**, go to **SECTION C**)

Husband/Wife's First Name Husband/Wife's Social Security Number

Husband/Wife's Middle Initial Husband/Wife's Last Name

SECTION B - INFORMATION ABOUT YOUR HUSBAND/WIFE, CONTINUED

2) How many employees work for your husband/wife's employer? (Please include your husband/wife).

Don't know ☐ 20 or more ☐ less than 20 ☐ (if less than 20, **STOP**, go to **SECTION C**)

Please provide information about the employer and the employer group health plan in the spaces below:

EMPLOYER NAME

ADDRESS

ADDRESS

CITY STATE ZIP

NAME OF GROUP HEALTH PLAN

ADDRESS

ADDRESS

CITY STATE ZIP

GROUP IDENTIFICATION NUMBER

POLICY NUMBER

3) Does your husband/wife's employer's group health plan cover prescription drugs? **YES** ☐ **NO** ☐

(If **NO**, **STOP**, go to **SECTION C**)

Please use your husband/wife's insurance card to provide the following information if available:

Rx GROUP Rx PCN

MEMBER ID Rx BIN

SECTION C - MORE INFORMATION ABOUT YOU

1) Are **YOU** receiving **Black Lung** Benefits? **YES** ☐ **NO** ☐

2) Are **YOU** receiving **Worker's Compensation** Benefits? **YES** ☐ **NO** ☐

3) Are **YOU** receiving treatment for an injury or illness which another party could be held responsible or could be covered under no-fault, automobile, or liability insurance? **YES** ☐ **NO** ☐

If you answered **YES** to any of these questions, go to **SECTION D.**
If you answered **NO** to all of these questions, sign and return only this page.

Your Signature

AREA CODE **PHONE NUMBER**

SECTION D - MORE INFORMATION ABOUT YOU, CONTINUED

3) If **YOU** are now getting any treatment for an illness or injury for which another party could be held liable, please print the date of illness or injury: M M – D D – Y Y Y Y

NAME OF INSURANCE CARRIER

ADDRESS

ADDRESS

CITY STATE ZIP

POLICY or CLAIM NUMBER

NAME OF ATTORNEY (If Applicable)

ADDRESS

ADDRESS

CITY STATE ZIP

BRIEF DESCRIPTION OF ILLNESS OR INJURY

4) If **YOU** are now getting any treatment for an illness or injury which could be covered under **no-fault** or **automobile insurance**, print the date the of illness or injury: M M – D D – Y Y Y Y

NAME OF INSURANCE CARRIER

ADDRESS

ADDRESS

CITY STATE ZIP

POLICY or CLAIM NUMBER

NAME OF ATTORNEY (If Applicable)

ADDRESS

ADDRESS

CITY STATE ZIP

BRIEF DESCRIPTION OF ILLNESS OR INJURY

Your Signature

AREA CODE **PHONE NUMBER**

OMB NO. 0938-0214

Patient's Name: Medicare # (HICN):

ADVANCE BENEFICIARY NOTICE (ABN)

NOTE: You need to make a choice about receiving these health care items or services.

We expect that Medicare will not pay for the item(s) or service(s) that are described below. Medicare does not pay for all of your health care costs. Medicare only pays for covered items and services when Medicare rules are met. The fact that Medicare may not pay for a particular item or service does not mean that you should not receive it. There may be a good reason your doctor recommended it. Right now, in your case, **Medicare probably will not pay for –**

Items or Services:
Because:

The purpose of this form is to help you make an informed choice about whether or not you want to receive these items or services, knowing that you might have to pay for them yourself. Before you make a decision about your options, you should **read this entire notice carefully.**

- Ask us to explain, if you don't understand why Medicare probably won't pay.
- Ask us how much these items or services will cost you (**Estimated Cost: $**_____), in case you have to pay for them yourself or through other insurance.

PLEASE CHOOSE **ONE** OPTION. CHECK **ONE** BOX. **SIGN & DATE** YOUR CHOICE.

☐ **Option 1. YES. I want to receive these items or services.**

I understand that Medicare will not decide whether to pay unless I receive these items or services. Please submit my claim to Medicare. I understand that you may bill me for items or services and that I may have to pay the bill while Medicare is making its decision. If Medicare does pay, you will refund to me any payments I made to you that are due to me. If Medicare denies payment, I agree to be personally and fully responsible for payment. That is, I will pay personally, either out of pocket or through any other insurance that I have. I understand I can appeal Medicare's decision.

☐ **Option 2. NO. I have decided not to receive these items or services.**

I will not receive these items or services. I understand that you will not be able to submit a claim to Medicare and that I will not be able to appeal your opinion that Medicare won't pay.

Date **Signature of patient or person acting on patient's behalf**

NOTE: Your health information will be kept confidential. Any information that we collect about you on this form will be kept confidential in our offices. If a claim is submitted to Medicare, your health information on this form may be shared with Medicare. Your health information which Medicare sees will be kept confidential by Medicare.

OMB Approval No. 0938-0566 Form No. CMS-R-131-G (June 2002)

OMB Approval No. 0938-0781

Home Health Advance Beneficiary Notice

We, _____, your home health agency, are letting you know that we_____ with the following items and/or services:_____

_____

_____.

Because: _____

_____.

If you have questions about these changes, you can call us at (____)_____.
TTY/TDD users should call (____)_____.

The estimated cost of the items and/or services listed above is $_____.
We think you have _____ insurance that may cover these items and/or services. However, you may have other insurance that we are not aware of.

You have three options available to you. You must choose only one of these options by checking the box next to the option and then signing below:

- ☐ 1. I don't want the items and/or services listed above. I understand that I won't be billed and that I have no appeal rights since I will not receive those items and/or services.
- ☐ 2. I want the items and/or services listed above, and I agree to pay myself since I don't want a claim submitted to Medicare or any other insurance I have. I understand that I have no appeal rights since a claim won't be submitted to Medicare.
- ☐ 3. I want the items and/or services listed above, and I agree to pay for the items and/or services myself if Medicare or my other insurance doesn't pay. Send the claim to (**Please check one or both boxes**):
  - ☐ Medicare
  - ☐ my other insurance: _____

Please note: If you select option 3 and a claim is submitted to Medicare, you will get a Medicare Summary Notice (MSN) showing Medicare's official payment decision. If the MSN indicates that Medicare won't pay all or part of your claim, you may appeal Medicare's decision by following the appeal procedures in the MSN. If you don't receive a MSN for your claim, you can call Medicare at: (___) _____. TTY: (___) _____. You may have to pay the full cost at the time you get the items and/or services. If Medicare or your other insurance decides to pay for all or part of the items and/or services that you have already paid for, you should receive a refund for the appropriate amount.

By signing below, I understand that I received this notice because this Home Health Agency believes Medicare will not pay for the items/services listed, and I chose the option checked above because they told me Medicare may not pay.

Patient's Name	Medicare # (HICN)
Signature of the Patient or of the Authorized Representative	Date

Please read and sign this form. Return it to the address at the top of this notice.

SKILLED NURSING FACILITY'S NAME & ADDRESS
TELEPHONE NO. AND TTYTDD NO.

Skilled Nursing Facility Advance Beneficiary Notice (SNFABN)

Date of Notice:_____

NOTE: You need to make a choice about receiving these health care items or services.

It is not Medicare's opinion, but our opinion, that Medicare will not pay for the item(s) or service(s) described below. Medicare does not pay for all of your health care costs. Medicare only pays for covered items and services when Medicare rules are met. The fact that Medicare may not pay for a particular item or service does not mean that you should not receive it. There may be a good reason to receive it. Right now, in your case, **Medicare probably will not pay for –**

Items or Services:

Because:

The purpose of this form is to help you make an informed choice about whether or not you want to receive these items or services, knowing that you might have to pay for them yourself. Before you make a decision about your options, you should **read this entire notice carefully**.

- Ask us to explain, if you don't understand why Medicare probably won't pay.
- Ask us how much these items or services will cost you (**Estimated Cost: $**_____), in case you have to pay for them yourself or through other insurance you may have. Your other insurance is:_____
- If in 90 days you have not gotten a decision on your claim, contact the Medicare contractor at: Address:_____ _____ or at: Telephone: _____TTY/TDD:_____.
- If you receive these items or services, we will submit your claim for them to Medicare.

PLEASE CHOOSE **ONE** OPTION. CHECK **ONE** BOX. **DATE & SIGN** THIS NOTICE.

☐ **Option 1. YES. I want to receive these items or services.** I understand that Medicare will not decide whether to pay unless I receive these items or services. I understand you will notify me when my claim is submitted and that you will not bill me for these items or services until Medicare makes its decision. If Medicare denies payment, I agree to be personally and fully responsible for payment. That is, I will pay personally, either out of pocket or through any other insurance that I have. I understand that I can appeal Medicare's decision.

☐ **Option 2. NO. I will not receive these items or services.** I understand that you will not be able to submit a claim to Medicare and that I will not be able to appeal your opinion that Medicare won't pay. I understand that, in the case of any physician-ordered items or services, I should notify my doctor who ordered them that I did not receive them.

Patient's Name:_____ **Medicare # (HICN):**_____

_____ _____
Date **Signature of the patient or of the authorized representative**

Form No. CMS-10055

Hospital Letterhead

Hospital ABN 2.

_____
Date of Notice

_____ _____
Name of Patient Admission Date

_____ _____
Address Health Insurance Claim (HIC) Number

_____ _____
City, State, Zip Code Attending Physician's Name

YOUR IMMEDIATE ATTENTION IS REQUIRED

Dear _____: (*Insert the name of the addressee.*)

This notice is to inform you that we have reviewed the medical services you have received for *(specify services or condition)* from *(date of admission)* through *(date of last day reviewed)*. Your attending physician has been advised and has concurred that beginning *(specify date of first noncovered day)* further *(specify services to be furnished or condition to be treated) (specify is/are medically unnecessary)* or *(could be furnished safely in another setting)*. This determination was based upon our understanding and interpretation of available Medicare coverage policies and guidelines.

You are financially liable for all costs for the care you receive, except for those services for which you are eligible under Part B beginning on *(specify date)*.1/ If you leave on *(specify date)*1/, you will not be liable for costs for care except for payment of deductible, coinsurance, or any convenience services or items normally not covered by Medicare. You should discuss other arrangements with your attending physician for any further health care you may require. However, this notice is not an official Medicare determination. The *(name of QIO)* is the Quality Improvement Organization (QIO) authorized by the Medicare program to review inpatient hospital services provided to Medicare patients in the State of *(name of State)*, and to make that determination.

- **If you disagree with our conclusion:**

  Request immediately, **by noon of the first working day** after receipt of this notice, an **immediate review by telephone, or in writing**. You may make this request through us or directly to the QIO at the address listed below.

  The QIO will request your views about your case and respond to you within one working day of receipt of your request and your medical records (sent by the hospital).

- **If you do not request review by noon of the first working day after receipt of this notice:**

  You may still request QIO review at any point during your stay or within 30 days after you receive this notice, whichever is longer. Request this QIO review at the address listed below.

- **QIO Review Results:**

  The QIO will send you a formal determination of the medical necessity and appropriateness of your hospitalization, and will inform you of your reconsideration rights.

  IF THE QIO DISAGREES WITH THE HOSPITAL (i.e., it determines that your care is covered by Medicare), you will be refunded any amount collected by the hospital except for any applicable amounts for deductible, coinsurance, and convenience services or items normally not covered by Medicare.

  IF THE QIO AGREES WITH THE HOSPITAL:

  You are responsible for payment for all services beginning on *(specify date)*1/ unless you have requested an immediate review.

  If you request an immediate review (i.e., you make your request for review by noon of the first working day after receipt of this notice), you will not be responsible for payment until noon of the next day after you receive the QIO's notification.

- **QIO Address:**
  (QIO Name)
  (Address)
  (Telephone Number)

Sincerely,

_____
(Title, e.g., Chairperson of Utilization Review Committee, Medical Staff, etc.)

ACKNOWLEDGMENT OF RECEIPT OF NOTICE

This is to acknowledge that I received this notice of noncoverage of services from _____ *Name of Hospital* _____ at ____ *Time* ____ on _____ *Date* _____. I understand that my signature below does not indicate that I agree with the notice, only that I have received a copy of the notice.

_____	_____	_____
Signature of patient or authorized representative	Time	Date

cc: QIO
Attending Physician

October 2003 - Form CMS-10092-B.

1/ For PPS hospitals and short term/acute care hospitals in waivered States, insert: the date of the third day following the date of receipt of the hospital notice.
For specialty hospitals and PPS exempt units, insert: the date of the day following the date of receipt of the notice.

NOTICE OF EXCLUSIONS FROM MEDICARE BENEFITS (NEMB)

There are items and services for which Medicare will not pay.

- Medicare does **not** pay for all of your health care costs. Medicare only pays for covered benefits. **Some items and services are not Medicare benefits and Medicare will not pay for them.**
- When you receive an item or service that is **not** a Medicare benefit, **you are responsible to pay for it,** personally or through any other insurance that you may have.

The purpose of this notice is to help you make an informed choice about whether or not you want to receive these items or services, knowing that you will have to pay for them yourself. **Before you make a decision, you should read this entire notice carefully.**
Ask us to explain, if you don't understand why Medicare won't pay.
Ask us how much these items or services will cost you (**Estimated Cost: $**_____).

Medicare will not pay for: _____
_____;

☐ **1. Because it does not meet the definition of any Medicare benefit.**

☐ **2. Because of the following exclusion * from Medicare benefits:**

- □ Personal comfort items.
- □ Most shots (vaccinations).
- □ Hearing aids and hearing examinations.
- □ Most outpatient prescription drugs.
- □ Orthopedic shoes and foot supports (orthotics).
- □ Health care received outside of the USA.
- □ Services required as a result of war.
- □ Routine physicals and most tests for screening.
- □ Routine eye care, eyeglasses and examinations.
- □ Cosmetic surgery.
- □ Dental care and dentures (in most cases).
- □ Routine foot care and flat foot care.
- □ Services by immediate relatives.
- □ Services under a physician's private contract.
- □ Services paid for by a governmental entity that is not Medicare.
- □ Services for which the patient has no legal obligation to pay.
- □ Home health services furnished under a plan of care, if the agency does not submit the claim.
- □ Items and services excluded under the Assisted Suicide Funding Restriction Act of 1997.
- □ Items or services furnished in a competitive acquisition area by any entity that does not have a contract with the Department of Health and Human Services (except in a case of urgent need).
- □ Physicians' services performed by a physician assistant, midwife, psychologist, or nurse anesthetist, when furnished to an inpatient, unless they are furnished under arrangements by the hospital.
- □ Items and services furnished to an individual who is a resident of a skilled nursing facility (a SNF) or of a part of a facility that includes a SNF, unless they are furnished under arrangements by the SNF.
- □ Services of an assistant at surgery without prior approval from the peer review organization.
- □ Outpatient occupational and physical therapy services furnished incident to a physician's services.

*** This is only a general summary of exclusions from Medicare benefits. It is not a legal document. The official Medicare program provisions are contained in relevant laws, regulations, and rulings.**

Medicare overview exercise

1. What is Medicare?

2. What year did the Medicare become effective?

3. Medicare, like Social Security, was never intended to pay 100 percent of a retiree's needs. T _____ F _____

4. Medicare will only pay for services that are (two words):

5. What agency administers the Medicare program?

6. What is a Medicare "carrier"?

7. What federal agency handles Medicare eligibility and enrollment?

8. Describe Medicare's initial enrollment period.

9. The date of one's enrollment has no significance as far as the effective date of coverage. T _____ F _____

10. Describe Medicare's general enrollment period.

11. Are there penalties for late enrollment in Medicare? Yes _____ No _____

12. Describe Medicare's special enrollment period.

13. Who files Medicare claims? Provider _____ Beneficiary _____

Word match

_____ Medicare Part A
_____ Medicare Part C
_____ Medicare Part D
_____ Deductible
_____ CMS
_____ Initial Enrollment Period
_____ ABN
_____ Medicare Part B

A. A flat dollar amount the beneficiary is responsible for before Medicare coverage will begin

B. A form for the beneficiary to sign telling the individual Medicare will likely not cover the service

C. Alternatives to Original Medicare

D. The Medicare prescription drug plan

E. Centers for Medicare and Medicaid Services/administers the Medicare program

F. Medical coverage for Medicare

G. Hospital coverage for Medicare

H. The seven month period surrounding Medicare eligibility for those turning 65 who have not been receiving Social Security benefits